

(PLEASE TYPE OR PRINT)



Horizon Blue Cross Blue Shield of New Jersey
Healthcare Choice plan please submit claims to:
P.O. Box 820, Newark, New Jersey 07101-0820
All other claims please submit to:
P.O. Box 1609, Newark, New Jersey 07101-1609



Health Insurance Claim Form

	1. POLICYHOLDER'S NAME (Last, First, Middle Initial)		2. POLICYHOLDER'S IDENTIFICATION NUMBER PREFIX (if any) NUMBER PORTION		SUFFIX (if any)	
æ	3. POLICYHOLDER'S ADDRESS (No., Street)	CITY		STATE	ZIP CODE	
3. POLICYHOLDER'S ADDRESS (No., Street) CITY STATE ZIP COL 4. TELEPHONE NUMBER (Include Area Code) 5. POLICYHOLDER'S SOCIAL SECURITY NUMBER 6. POLICYHOLDER'S BIRTH DATE Month Day Year					ZIF CODE	
<u>\</u>	4. TELEPHONE NUMBER (Include Area Code) 5. POLICYHOLDER'S SOCIAL SECURITY N		JMBER	6. POLICYHOLDER'S BIRTH DATE	6a. POLICYHOLDER'S SEX	
P01				Month Day Year	Male Female	
-	7. EMPLOYER'S NAME			8. IF THIS IS A GROUP POLICY, INI	DICATE THE GROUP NUMBER	
	9. PATIENT'S NAME (Last, First, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? YES NO			
ļ			- `	(Current or Previous)		
PATIENT	11. PATIENT'S BIRTH DATE Month		b. AUTO ACCIDENT YES NO STATE IN WHICH AUTO ACCIDENT OCCURRED: c. OTHER ACCIDENT YES NO			
II. P/	/		d. DATE OF ACCIDENT DATE OF YOUR FIRST SYMPTOM OF ILLNESS			
-	13. PATIENT'S RELATIONSHIP TO POLICYHOLDER 14. IS PATIENT Employed			Month Day Year Or, if Pregnant, Month Day Year		
L	Holder Spouse Child Other Student Student — / — Menstrual Period — / — /					
F BENEFITS	15. DOES THE PATIENT HAVE OTHER HEALTH INSUF	15a-h AND SEE	15a. IF MEDICARE, CHECK HER AND ATTACH EOMB			
	YES NO		(See instructions and example of	f EOMB on back)		
			15c. OTHE	R POLICYHOLDER'S BIRTH DATE th Day Year / /	15d. OTHER POLICYHOLDER'S SEX Male Female	
N OF	15e. OTHER POLICYHOLDER'S ADDRESS (No., Street)	CITY		STATE	ZIP CODE	
ATIO						
COORDINATION	15f. OTHER INSURANCE PLAN'S NAME		15g. OTHER POLICYHOLDER'S IDENTIFICATION NUMBER AND GROUP NUMBER			
≡ 0	15h. OTHER INSURANCE PLAN'S ADDRESS (No., Stre	et) CITY		STATE	ZIP CODE	
16. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to Horizon Blue Cross Blue Shield of New Jersey, all medical or other information requested for the processing of this claim form. I hereby agree to reimburse Horizon Blue Cross Blue Shield of New Jersey in full, should this claim be incorrectly paid. AUTHORIZED SIGNATURE DATE (AREA CODE) HOME PHONE (AREA CODE) WORK PHONE						
WHEN YOU ARE SUBMITTING EXPENSES FOR MORE THAN ONE FAMILY MEMBER, PLEASE USE A SEPARATE CLAIM FORM FOR EACH PERSON.						
ITEMIZED BILLS FOR COVERED SERVICES OR SUPPLIES MUST BE ATTACHED TO THIS FORM AND INCLUDE THE FOLLOWING:						
Check that each itemized bill is legible and contains ALL of the following information:						
NAME & ADDRESS of person or institution rendering the service or supplying the item PROVIDER'S Federal Tax Identification Number BILLS MISSING ANY OF						
PATIENT'S FULL NAME THIS INFORMATION WILL						
	DATE each service rendered or item supplied					
	AMOUNT charged for each service rendered or item supplied DIAGNOSIS of ailment					
Cash register receipts, cancelled checks, money order receipts, personal itemizations, and bills only noting a "balance due" are not acceptable.						
17. AUTHORIZATION FOR ASSIGNMENT OF BENEFITS Horizon Blue Cross Blue Shield of New Jersey, at its discretion, may accept an Assignment of Benefits. I the undersigned, authorize and request Horizon Blue Cross Blue Shield of New Jersey, to make payment for benefits which may be due herein to:						
	NAME OF PROVIDER PROVIDE	R'S TAX OR SOCIAL SECURITY NUMBER	SIGNATURE OF POLICY	HOLDER	DATE	

PLEASE READ THIS IMPORTANT INFORMATION

COORDINATION OF BENEFITS?

If the spouse or the policyholder/patient is covered by another health insurance program, please provide the information requested in Section III. Example: Spouse covered by another insurance company or other Horizon Blue Cross Blue Shield of New Jersey coverage.

When submitting charges for services or supplies that have been partially paid or declined by other group health insurance, attach a copy of the Notice of Payment or Explanation of Benefits from the other health care insurer along with itemized bill(s).

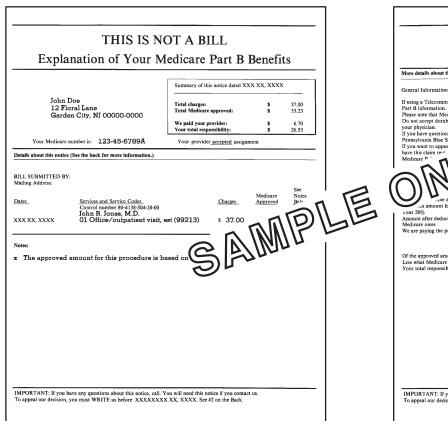
MEDICARE?

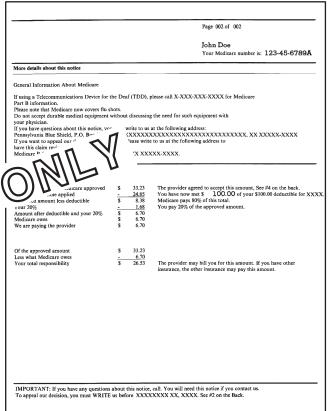
If PATIENT is eligible for Medicare Benefits, be sure you include the Explanation of Medicare Benefits (EOMB) that was sent to patient explaining the charges paid or not paid by Medicare.

To process a claim for you Horizon Blue Cross Blue Shield of New Jersey, supplementary insurance, we need a copy of the Explanation of Medicare Benefits (EOMB). This EOMB should have been sent to you when Medicare processed your claim. If your EOMB has more than one page, send us copies of all pages. Please write your Horizon Blue Cross Blue Shield identification number clearly on the first page.

CLAIM FORM WILL BE RETURNED TO YOU IF THIS ADDITIONAL INFORMATION IS NOT SUPPLIED

An example of an Explanation of Medicare Benefits (EOMB) is displayed below.





HELPFUL HINTS

When you are submitting expenses for more than one family member, please use a separate claim form for each person.

It is suggested that you make copies for your own use before you submit the original bills.

Durable medical equipment? (Wheel chair, crutches, braces, oxygen, etc.) Your doctor's certification must be submitted indicating the expected length of time the equipment will be in use. If renting, please have your medical equipment supplier also indicate the purchase price of the equipment on the bill.

Prescription Drugs? Bills must show the prescription number, name and quantity of drug, and the name and address of the pharmacy.

Please mail completed claim form to:

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FRAUD WARNING —

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES

TO REPORT SUSPECTED FRAUD CALL 1-800-624-2048 AT HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY